Enhancing Partnerships between Title V, Medicaid, and Local Health Departments through EPSDT

JAMES RESNICK: Greetings and welcome to our webcast Enhancing Partnerships between Title V, Medicaid, and Local Health Departments through EPSDT.
Before we begin our presentation, I would like to start with a few instructions.
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Please take a couple of minutes to do so.
Your responses will help us to plan future broadcasts in this series and improve our technical support.
It is now my pleasure to introduce the acting deputy associate administrator for.

CHRIS DEGRAW: It gives me great pleasure to the webcast Enhancing Partnerships between Title V, Medicaid, and Local Health Departments through EPSDT.
I want to bring you greetings from Dr. Peter van Dyck.

He was scheduled to participate in this broadcast but had to be out of town suddenly at the last moment.
So I'm pleased to be here to welcome you on his behalf.
This note worthy occasion sponsored by the Maternal and Child Health Bureau has brought our partners, the centers for Medicaid services.
The child health insurance programs and health departments to focus on early diagnosis and treatment called EPSDT.
It is under the state's Medicaid and Title V programs.

Currently the Maternal and Child Health Bureau provides funds to state through the MCH block grant program to provide direct healthcare to pregnant women and children, including children with special healthcare needs.
Block grant funds make it possible for communities to put in place prevention services including immunization, child injury and lead poisoning prevention programs and newborn screening programs.
States and communities use these funds to expand access to healthcare for more than 27 million women, infants and children.
Collaboration between state Maternal and Child Health Bureau, Medicaid and health departments is important in reaching all children eligible for EPSDT which provides direct and enabling services.

As a preventive approaches services will enable children to live healthy, longer and more productive lives.
We thank you for your time and participation in this webcast.
Please note that this webcast will be recorded and archived and available in a couple of days at the website.
At this point I would now like to introduce my colleague from the centers for Medicaid services Dr. Jerry Zellinger.
He's technical director and medical adviser in the Division of Benefits, coverage and payments.
Dr. Zellinger.

JERRY ZELLINGER: I likewise want to welcome you to today's webcast.
And give you greetings from Rhonda Rhodes who is the director of Division of Benefits, coverage and payment in the Medicaid program here in Baltimore.
CMS is pleased to collaborate with HRSA on this project.
We share a number of important goals and we partner on a number of different issues together.
Our basic common goal, of course, is ensuring quality and access to healthcare for children.

And this webcast represents an excellent opportunity for Title V folks to learn more about EPSDT and vice versa for Medicaid folks to learn more about Title V programs and ways to partner.
Just to mention in closing, Medicaid now covers more than 35% of all births in the country.
There are about 25 million children under 21 enrolled in the Medicaid program and we spend over $38 billion annually on the EPSDT program.
Thank you for your participation and I'm sure you'll enjoy the webcast.

JAMES RESNICK: Thank you very much.
It is now my pleasure to introduce Cindy Ruff, who is also with the Center for Medicare and Medicaid services commonly known as CMS.
She is a healthcare special within the Division of Benefits, coverage and payments.
I now present Cindy.

CINDY RUFF: Thank you, Jamie.
I'm going to give you an overview of the requirements for EPSDT services.
EPSDT and for early and periodic screening, diagnostic and treatment services.
It's a preventive and comprehensive program for Medicaid eligible individuals under the age of 21.
EPSDT provides children with access to comprehensive and periodic evaluations of their health, development, nutritional status as well as vision, dental and hearing services.
EPSDT is a mandatory service for most Medicaid-eligible individuals.
The exceptions to that would be the Medicaid needy population under Medicaid which it is optional.
Most states do include EPSDT for that population.

A state such as the State of Oregon which has a statewide demonstration waiver has been allowed to waive some of the EPSDT service requirements and also CMS has health insurance flexibility and accountability initiatives.
These waivers also in some instances do allow states to waive some of the EPSDT service requirements.
But for the most part we need to continue to say that most Medicaid eligibles are entitled to EPSDT services.
As part of the preventive aspect of the service, periodic examinations or screenings assure that health problems are diagnosed and treated early before they become more complex and the treatment becomes more costly.

Schedules for screening, dental herg and vision services must be provided as intervals that meet reasonable standards of medical and dental practice.
And states are required to set their own schedules.
It is not something that CMS has the authority to do.
So states need to consult with a medical or dental organization in their state to determine these schedules or we do say that they are allowed to adopt a national schedule such as the American pediatric schedule.
They may also do that.

It requires screening services under EPSDT as defined by the statute include a comprehensive health and developmental assessment and history.
A comprehensive physical exam.
Appropriate immunizations according to the advisory committee's schedule.
Laboratory tests including a blood assessment which I'll come back to in a minute and health education.
Those five elements are spelled out in the statute.
Back to the laboratory tests.
The only mandatory tests under the Medicaid program from CMS is lead toxicity screening.
We do require that all children, all Medicaid children who are considered at risk must be screened for lead poisoning at 12 to 24 months of age.
Every child up to 72 months where there is no record for screening should also be tested.

The other tests are left to the discretion of the state.
States set their own testing schedules.
In addition, vision services including eyeglasses, hearing services including hearing aids and -- are required.
Dental services are also included and at a minimum must include release of pain and restoration of teeth, maintenance of dental health.
They may not be limited to emergency services for EPSDT recipients.
There are many states now cutting back on services, adult dental being one of them.

But they are not allowed to cut back on services for EPSDT children.
As part of diagnosis, when a screening examination indicates the need for further evaluation, any diagnostic service must be provided.

The indicate that a referral should be made without delay and states should provide follow-up to make sure the child receives a complete diagnostic evaluation.
One of the biggest parts of EPSDT is the treatment portion.
This was changed in 1989.
Healthcare must be made available for treatment and other measures to correct or improve illnesses or conditions discovered by the screening service.
All Medicaid coverable medically necessary services must be provided even if that service is not available under the state plan to other Medicaid eligibles.
The state Medicaid agencies determines that.
Discovered by a screen, let me explain.

We have developed a very broad definition of a screen, which is that any encounter with a health professional practicing within the scope of their practice is considered a screen.
And the reason we did this was to make sure that children with conditions who possibly were not eligible for Medicaid when that condition was discovered or born with a certain condition would not be left out of the EPSDT mandatory treatment requirements.
Next we'll go into the required state activities.
States are required to informs all Medicaid eligible children under 21 and their families or guardians that EPSDT services are available.
States are required to set distinct schedules for screening, dental, vision and hearing services.

States are required to report annually on the CMS form 416 their EPSDT performance data.
States are also required to informal Medicaid eligible children that transportation and appointment scheduling assistance is available upon request.
Some of the things we had CMS do is provide states with technical assistance, data and evaluation results to facilitate EPSDT program implementation.
We do collect and analyze the CMS416 data and it gets posted on our website when it's complete.
I've listed a few issues for discussion here, some of the things that seem to come up from time to time.
Managed care on EPSDT has provided some tricky problems.
If health plans and providers are not informed of the broad package of benefits offered under EPSDT and their responsibility to provide the covered services it can cause confusion and potential underutilization.
We found some states that actually put in their plans, put in their contracts with their managed care plans EPSDT requirements.

They sometimes put in there the specific participation goals and they clearly spell out.

On the other hand there are some states that don't do that and I think that may cause some confusion with providers who really aren't sure what EPSDT means.
Another issue here is EPSDT litigation activities.
Many states are involved-in-law suits regarding the provision of EPSDT services.
Some of the issues raised are the 80% participation goal.
Informing requirements and access to services, specifically mental health services and dental services seem to be some of the biggest areas.
That's all I have right now.
I would like to give you our website.
I apologize for not having it on the slides.
We have an EPSDT webpage that you can go to that contains much of this information and has other contact information on there.
That webpage is CMS.HHS.gov/Medicaid/EPSDT/DEFAU LT.ASP and you can go to that webpage for additional information or contact information.
Thank you.

JAMES RESNICK: Thank you so much.
It is now my pleasure to introduce the next speaker, Phyllis Sloyer, who works at the Florida Department of Health and is the division director of the children's medical services.
This is the Title V program, children with special healthcare needs.
Thank you very much, Phyllis.

PHYLLIS J. SLOYER: Thank you and good afternoon everyone.
I'm going to talk about putting the T into action from a state and grass roots perspective with respect to early periodic screening diagnosis and treatment and give some examples about partnership possibilities and how one can get to the T and some of the other roles that Title V may play in collaboration with the Medicaid program.
We begin with some of the partnership possibilities and I'll speak from an experience perspective about some of the experiences here in the State of Florida.

One of the possibilities is actually using the Title V program to identify specialty and unique services for the Medicaid agency for children who may need some rather complicated treatment.
For example, Title V has established relationships with certain centers of excellence and actually in some cases may have

developed standards for designation of those centers, whether they be cranial facial, spine -- it is not uncommon for us to be contacted by a medical agency.
We provide that kind of assistance to the Medicaid agency and actually it has become a very fruitful partnership.
There are other partnership possibilities as well.

In particular, two very early partnership possibilities in a child's life.
One of those has to do with the Title V role and follow-up for the newborn screening program where you actually find babies who may have abnormal conditions.
It it good to make sure they actually get into the screening program and get the follow-up treatment.
The critical role with Title V and a good partnership possibility with the Medicaid program.
The other role that Title V may play has to do with the early intervention program.

In many states, Title V actually is the lead agency for part C, or early intervention and indeed may also have other early intervention programs for at-risk infants and toddlers.
Again, a very good source of identification of individuals who need treatment and actually getting them into early treatment and early intervention programs.
I would add here another role that is possible with respect to early intervention has to do with the lead screening intervention.
In our state, toddlers who have a certain blood lead level are actually referred to the Title V children with special healthcare needs program for additional evaluation and management should that be necessary.
So a good role again for Title V with respect to EPSDT and lead screening.
Let me talk a little bit about getting to the T, or treatment.
Probably one of the sort of old roles for Title V may be one of care coordination and assisting families and geting to treatment service.
Whether it's providing support services to access treatment through care coordinators such as facilitating transportation services or supporting care coordination as a part of the medical home.
Certainly a venue where children receive the EPSDT services.

And I would add that in the past ten years or so a very critical component to getting to that T is the parent collaboration that has developed in the Title V system and certainly a very good linkage for children who need to get to that T.

I cannot say enough about the family-centered care aspect of the early periodic screening diagnosis and treatment program.
Let me move on to another role that Title V may play, and that is one of assisting the Medicaid agency in determining medical necessity.
Title V can make available certainly to the Medicaid agency consultant expertise, whether that be a physician specialty or other healthcare provider.
Or they may actually offer team arrangements that assist the Medicaid agency in reviewing medical necessity and helping them make a recommendation.
For example, we have some unique teams that are comprised of pediatricians, nurses and social workers and they pull together a variety of providers to make recommendations to Medicaid concerning medical necessity for certain services, whether that be private duty nursing or certain durable medical equipment or other technologies.

A very beneficial role and one that Title V can make available to the Medicaid program.
We also have partnered with the Medicaid program in looking at utilization patterns.
In particular in our state looking at some of the private duty nursing utilization patterns and making recommendations for, perhaps, more effective treatment modalities or making recommendations on better options for families in the community.
In a nutshell, there are quite a few roles that Title V can play as a partner with the Medicaid agency.

We do bring to the table some of that medical expertise that -- that is very beneficial.
In particular the Title V children with special healthcare needs program has a long history of working with specialists in communities to assure appropriate care for children with special healthcare needs.
I think no matter what avenue you may have available to you, in conclusion, it's one of those looking at your strengths, where do you have strengths to bring to the table with the Medicaid entity?
What can you bring to the table?
Is there someone who can advocate for you with the Medicaid program?
All in all, the Title V partnership with Medicaid in Florida has been an extremely beneficial and fruitful partnership and one that I believe has served children well.
And I have to say it's probably one of the best partnerships we've had.

JAMES RESNICK: Thank you very, very much.
It is now again my pleasure to reintroduce Cindy Ruff who will be speaking on monitoring and reporting, navigateing through form CMS416.

CINDY RUFF: Let me start by saying that the data reporting from the EPSDT services as required as part of the over 89 legislation for the first time states were required to report certain data to CMS.
And the statute requires that they report to us four elements. Number of children provided child health screening services, the number of children referred for corrective treatment, the number of children receiving dental services, and the states' results in attaining the participation goals set for the state as part of section 1905R which happens to be the definition of EPSDT.

As you can see based on those four elements, we needed to do something to get to this participation goal.
So at the time it was created the 416, now the CMS416.
In addition, we had to add other data elements to that form.
As an example, we currently ask that the state include their state schedule on the form.
We also ask for the average period of eligibility.
And most recently we've added the total number of eligibles in managed care and we've also asked for the total number of screening blood lead tests.
Blood lead screening is a very important issue for CMS and the 416 is the perfect place to ask for that kind of data which we don't get elsewhere.
The data collected on the 416 is used to determine the participation ratio as required by the statute and also a screening ratio.
The participation ratio is defined as the number of children receiving at least one screen in a year.

Screening ratio indicates the extent to which EPSDT eligibles receive the number of initial and periodic screening services that is required by the state's schedule.
That number is adjusted by the portion of a year that the individuals are eligible for Medicaid.
Participation goal was set by CMS on behalf of the secretary in 1990.
CMS also set incremental goals at that time for states and states were to achieve 80% participation by 1995.
The goal of 80% has not changed, even though some states have not achieved an 80% goal.

There are inherent problems with the 416 which we can work on and I can talk about those in a little while.
CMS has no authority to sanction states for not attaining the 80% goal.
We do continue to work with states to improve the accurate and consistent reporting.
416 has been revised twice since its first version.
The last time was in 1999.

And we changed it at that point in time to include some information that we hoped would make reporting easier for states who had primarily managed care.
We included CPC care that the states could count as opposed to actually having to compile a list of the five elements of the screen.
Included some B codes that would be counted.
It's when we added the lead screening data and when we changed it to include the managed care data.
The line for corrective treatment is very difficult for states to collect at this point.
That may be changing with a new referral code that is being -- going to be used under HIPA.
We had some disagreements or discussions with individuals by changing the 416.
They indicated that the data would not be comparable and we would not be able to compare state data from state to state because we were using various schedules but we disagreed, indicating that we felt we needed to judge each state according to its own schedule as opposed to judging it to the old American academy of pediatrics schedule which is no longer being used.
So we felt we made some significant improvements in 1999.
Unfortunately we still have some additional issues.
That includes reporting managed care data continues to be a problem.
For states that do not require certain data from their managed care plans as part of their contracts they find it difficult to support the screenings for children in managed care if they're paying a per member per month fee and not getting any data back.
There is also quite a bit of litigation regarding the state's achievement of the 80% goal.

Many courts across the nation have seen the 80% as a requirement and while that's not CMS's view of the 80%, courts see it that way and are trying to hold certain states to that number.
Final thing I've included here as part of the presentation is a copy of the HIPA416.

The last column I was for some reason not able to get that to show up on this form.
But just to go through the listing the things.
We start out asking for the total eligibles for EPSDT in the state.
The CN and MN is the categorically needy.
The mandatory population, and the medically needy.
The age breakouts.
We do the underage 1 and then we break out 1 to 2, 3 to 5, 6 to 9, 0 to 14, -- I can tell you the new breakouts as of 1999.
We were trying to get better data on adolescents.
Prior to that we had grouped the 19 to 20-year-old -- the 10 to 20-year-olds under one lump category so we broke it out.
We've included the state schedule.
We asked for the number of years in the group.
We put that in there.

We also asked for total months of eligibility because we understand that children are not eligible for a full year so it's not fair to hold the state to the number of screenings in that schedule for children only eligible for six to nine months of the year.
Then there is a calculation made that the expected number of screenings based on the eligibles and the schedules, which after some other calculations gives us the screening ratio.
That is the number of screenings that a child receives that they should have -- as opposed to what they should have received.
We then go to the more basic information which is the participation ratio, which is what is required by the statute.
And we ask the number of children who should have received at least one screen based on the state's schedule.
Number of eligibles who did receive at least one screen.
That's where the states count if they want to, the CPC codes we've given them.
The general health screening preventive codes we've given them.
They can use those counts and it gives us the participation ratio.
That is children who received at least one screen in a given year.
Total eligibles referred for corrective treatment, as I said that's not -- we don't get very good data in that, unfortunately.

That may be changing with the attachment that is being produced at this point.
Some states have no way to track that for rapid treatment.
It also does not mean that we know that corrective treatment has been received.
It simply indicates that a referral has been made.
Lines 12A through C are dental services.

We've expanded the information that we request on dental services to break it out as into any dental services, preventive dental services and treatment dental services.
We felt it was very important to understand exactly what kind of services children were receiving.
And it's actually another initiative we work on with HRSA so it's important for them, too, to know that information.
Total eligibles enrolled in managed care.
It gives us an idea with the problem in the data or low counts.
If we have a state that is primarily managed care we may need to work harder to get their data included.
The total number of screening blood lead tests for children under the age of 6 is the mandatory.
The last few columns are blocked out.
We do give states -- we ask them to report to us specifically in these blocks.

And I would mention that the website that I gave you before includes a link to the 416 form and the instructions.
And there is also some contact information on that webpage.
Teresa, for anyone who is interested, is the primary person who works on the 416.
Her name and number are on the website.
If you have any questions, contact her.
We also have on the website a link to the most recent data that you can feel free to go in and check any time you need to.
Thank you very much.

JAMES RESNICK: Somebody submitted a question.
Would it be possible if you could say the website address again?

CINDY RUFF: I'm sorry.
CMS.HHS.gov/Medicaid/EPSD T/DEFAULT.ASP.
If you have any trouble and you can just go to the CMS website and it will probably in the search mode it will probably bring you to the page if you have any trouble getting into it.

JAMES RESNICK: Thank you very much.
It is now my pleasure to introduce Rosemary Murphy who works with the Maryland Department of Health and mental hygiene and the deputy director of health choice and acute care administration within the Office of health services.
Thank you for being with us today.

ROSEMARY E. MURPHEY: Thank you, Jamie, for inviting me to participate.

This is especially gratifying because I spent the first half of my career working in Title V and the second half working in Medicaid at the state level.
What I want to do first is just a couple goals that I don't have on the slide and that's to present a brief overview of the relationship between medical assistance and Title V in Maryland to talk about how financing decisions have been -- challenges we're still facing.
Background on Maryland.
Maryland is the third richest state in the nation.
However, of our population of 5.4 million people, 27% of our kids are now on Medicaid.
It's 403,000 kids are covered by Medicaid.
60% of these kids are eligible for expansion programs such as chips or community based waivers.

We're fortunate in Maryland that our medical assistance program and our Title V program are both in the Department of Health and mental hygiene.
There are local health departments in 23 of our counties and Baltimore city.
I think it's important to note that Maryland is receiving 50% federal financial participation for CMS and our Medicaid budget is 3.8 billion dollars.
That is a B as in billion.
The managed care component of that is time.2 billion.
We receive $12 million in federal Title V money and the state has matching funds.
It was begun in 1997 as an 1115 waiver.
75% of all our health choice members are children.
92% of all children in Maryland are in managed care including our SSI and foster care populations.
Trends in Maryland.

The healthcare environment in Maryland is a strong hospital market regulatory system and managed care consumer protection.
Medicaid managed care operates statewide in this environment alongside the commercial plans.
They're relatively stable in our state.
We have seven plans.
We brought a new one on this month.
Six of our seven plans only serve the Medicaid population.
All are for-profit organizations.
Four MCO's operate statewide and three are owned in whole or in part by hospitals.
Want to talk a little bit about chip.
It operates as an expansion of Medicaid.

Beneficiaries are enrolled in health choice.
The total enrollment went from 300,000 in 1997 to over 450,000 presently.

A big jump were the number of adolescents that we're serving with the benefit of having chips.
Our current eligibility criteria for our chip program, because of the budget crisis we have had to lower our eligibility to 200% of poverty.
We were at 300% through a premium program.
A premium program now begins at 185%.
Children and families 185 to 200% of poverty will pay a monthly $37 premium.
That premium is for all children in the family.
Our existing premium program or pre-existing program is now frozen.
We cannot enroll any new members.
However, those that were enrolled as long as they maintain eligibility will be grandfathered in.
Those who pay a $40 monthly premium for 250% of poverty and those 250 to 300 pay a $50 a month premium.
Other things Maryland has experienced are the waivers.
We have 900 children in an autism waiver.
A longstanding home care model waiver program that has 200 children and we have about 200 kids in our DV waiver.
MA pays also for about one-third of all the births in our state.

Approximately 25,000 births we pay for a year.
Pregnant women are eligible for medical assistance as long as their income is less than 250% of poverty.
There is no asset test as there is none offered for children.
Family with income of $46,000, family of four would qualify for our program.
We do have a mail-in application.
We've done all the simplify indications that all the states have done.
We do enroll our pregnant women in our health choice program.
We also have been fortunate to have a family planning waiver for a number of years that provides coverage for women after they lose their other coverage, that 60 day post partum period.
Those women, however, just have family planning services and are not in managed care.

MCO's are required to pay for most benefits including EPSDT screenings and most of the diagnostic and treatment services.
Medical assistance pays for some fee for services and we do have some -- the core vows to our managed care programs are specialty

mental health, health services related to the special ed. populations and a number of case management programs.
As Cindy talks about states are required to provide kids under 21 all mandatory services including a full range of treatment services and all the optional services.
It is a challenge trying to do that through a managed care system because there is always that one unusual service that comes up.
We also have looked at the waivers to provide us with a broader sense of services that we can provide for some kids, including respite and facilitateive services.
Title V trends.
Prior to health choice Medicaid relied heavily on Title V as a direct service provider especially for prenatal care in our state.
They continue to serve many undocumented women on the eastern shore of our state and in the metro area.
Those women are not eligible for medical assistance.
A few of our local health departments also continue to have contracts with managed care organizations.
In areas of provider shortages.

Health choice has provisions that allow access to school base health centers.
Title V through our local health department continues to support some of the school-based health centers.
So you can see where we're shifting down the pyramid.
Now if we look at the pyramid which I'm sure all of you are HRSA are familiar with, the pyramid is showing us the core public health services that must be delivered by MCH agencies.
In our state we show the relationship of our Title V agency to public agencies and private agencies in this matter.
Medicaid plays a significant part in planning, implementing and evaluating population-based services.
I think that's because as we've covered more and more children, we're called to the table and asked to participate in a lot more venues.
Pregnancy prevention, emergency patient, injury prevention, oral health just to name a few.
We also have encouraged and involved our managed care organizations in many of these activities.
Medicaid managed care sports the pyramid shift.

The goals of our health choice program are to develop a patient focus system to create prevent oriented assistance of care.
Build on the strength of Maryland's public health infrastructure, hold them accountable for delivering high quality care and achieveing better value for state dollars.

Examples are outreach, care coordination, translation services, and transportation services.
The state also covers that through grants to local health departments which I'll talk about later.
There are also incentives for NCO's to collaborate on infrastructure.
It's a problem as they strive to provide services.
That is one area we do have a major shortage area in.
The partnership is essential.
The shift in the pyramid away from direct services we must not lose focus on the important of Medicaid as a source of payment for local health departments.
Local health departments can be a safety net in provider shortage areas.
They provide many of our targeted case management services to pregnant women and high risk children.
They also sponsor school-based health centers.
Medicaid fee for service rates are traditionally low.
One of the unique features of Title V allows medical assistance to pay Title V providers for actual costs across base rates.
Medicaid statute and Title V law requires interagency agreements between the two.

In that agreement we must assure maximum utilization of services available under the MCH program.
Utilizing the grantees to provide more effective use of the financing services.
It can be used to specify how the Title V services will be reimbursed.
Several other unique features of Title V that Medicaid agencies must be aware of.
Except for Title V, services which are free cannot be reimbursed by Medicaid.
That is except for Title V.
Medicaid is payer of last resort except for Title V services.
And, I might add, for school health-related services.
Registration for IEP.
That's an he exception.
We retain many of the roles for local health departments.
Partnership activities.
Maryland enjoys a long and rewarding partnership with our program.
During the last decade we've seen much expansion with shifts to managed care and throughout this time we've relied on Title V.
We periodically visit our MLU with Title V and recently decided to update the document using this framework.
We'll get back to that in a second.
Let's talk about reimbursement for healthcare services.

Medical assistance continues to make direct payments to Title V services delivered to service populations and targeted case management programs carved out of the managed care program.
Cost base rates.
Title V bills medical assistance only for the federal share of reimbursement or the 50% EPSDT.
We also require MCO's to pay for services designated as self-referral.
Payment must be at a minimum at the Medicaid fee for service rate for these self-referral services.
There is an impact on our local health department are health centers and family planning clinics.
July 2003 medical assistance had a significant increase in the reimbursement rate for evaluation and management codes.
The increase was built into the MCO rates and must be passed on to contracted providers and providers rendering self-referral services.
Medical assistance is required to pay federal qualified health centers a percentage of reasonable cost.

I believe this year it's 85% of reasonable cost.
MCO's pay market rates and medical assistance pays the difference.
Medical assistance is a major payer of mental health services in Maryland.
Challenged to define provider qualifications.
Find enough providers and we need assistance in determining medical necessity.
I think our previous speaker spoke to as the role that Title V could help with.
It's something we need help with.
And also to assure coordination with other agencies and services.
These children often have multiple problems and there are many agencies involved.
Medicaid reimbursement of enabling services.
Transportation and translation services are grant funded in our state.
We don't pay for them as a fee for service and again they are grants to local health departments.
The passage of over 89 Medicaid has paid for an array of services for pregnant women.
Health education, risk section, outpatient treatment, substance abuse and targeted case management for high risk children under age 2.
These are services that we provide through our local health departments even when women are enrolled in managed care.

Services to children were more recently enhanced through our home and community based waiver expansion.
I mentioned that before.
That's the only way we can get respite.
Medicaid reimbursement of population-based services.
Shooting down the pyramid.

Lead screening, immunization, we also do pay an administration fee for that.
Oral health screening services and again oral health is an area that we're challenged by and we need to collaborate to address this important issue.
Medicaid infrastructure building activities.
Examples of inextra structure building activities.
Medicaid and MCO's participate in infant mortality review teams, blood screenings and other initiatives.
The opportunities are limitless.
Outreach and eligibility.
We'll move back to the topic areas that we're writing our MOU so we'll look at eligibility.
Local health departments, health choice eligibility and enrollment.
These are some of the areas of collaboration that Title V and MA that have evolved through our experiences with EPSDT.
We started in the mid-80's with giving our local health department EPSDT grants and that expanded when we went into managed care.
They then assumed additional roles.
These roles are described specifically in MOU's in each of the local health departments.

The additional roles are the care coordination unit and those help in following up on missed appointment, if people are lost in care, they do outreach, education, informing.
Also local health departments also have people that help us with services when a recipient is having difficulty with their managed care organization when they feel they've had a denial of service.
Local health departments have contact with enrollys and provide us with feedback on what is going on in the community and our barometer when we're in trouble in terms of an area in terms of network issues.
Again it's that face the local health department can put on MA for the recipient in the community that we really value.
Networks and delivery systems and fiscal year 2003 Medicaid increased our physician fees, a $15 million total fund initiative.
Health choice has increased our network and ability to really serve our population.

There are still challenges ahead, especially the specialty services with children with special healthcare needs.
It provides a form for us to bring health plans together to collaborate and step back from the inevitable competition.
We have a monthly meeting of special needs coordinators and we bring a host of different folks in.

Title V is a frequent presenter to that group to talk about a lot of different topics to enhance the services provided to our clients.
Talk about lead screening, asthma.
Then we also do sharing back and forth because a lot of times agencies think that they're the only ones out there really dealing with the needs of the population and so we present some of their disease management programs and all of them do provide some pre-natal case management services.
That is very helpful for us to have that sharing.
The quality assurance.
I think this slide is pretty self-explanatory.
Title V and Medicaid share performance measures.
I know that Title V can choose some of their own measures now and they've added some that I think help us to have more synergy and work together.
And immunizations, Medicaid service utilization.
We look to our partners in Title V to help us with getting the folks who are in that program to utilize that service.
And also asthma initiatives are becoming a bigger issue in our state.
We tap into their expertise to help us develop policies and starred ards of care for our health plans and this has been particularly true in EPSDT.
Children with special healthcare needs.
Areas around HIV/AIDS and used their staff to help us with determinations with needs.

Lead case management has been another whole issue that we have a big problem in Maryland with and appreciate their expertise.
Especially proud of our efforts in reducing infant mortality.
In fiscal year 2000 we experienced our lowest ever infant mortality rate.
Two other initiatives, two of our leading causes of morbidity in our state, asthma and lead poisoning are areas that we're working on.
We'll continue to tap into them and we know that we have unique challenges serving the unique needs of children with special healthcare needs and currently looking at some redesign issues, a

semicomplicated program for some of our high-cost children that are currently not in a program.
Under data exchange and infrastructure Title V provides population level data for claiming and benchmarking.
Medicaid can provide counter data and we can extrapolate that to the general population.
We've done a good job in Maryland of getting our data.
We do have data for services provided in our managed care program.
I think we've done really well with that.
Population level databases promote public health.
Quality improvement for health plans and we do share datasets between Medicaid and public health.
One of them being our --
(Inaudible)
They help us with analyzing that and sharing that.
OK.

Our partnership is evolving in the early phase working with the department.
They play more of a role in eligibility in enrollment.
The Title V population became more of the Medicaid population and we reimburse schools, we did all of those easy things.
And then more recently we've been focusing on quality assurance.
Collaborating with standards.
We've had a lot of success in improve access to medical care in Maryland and stabilized our provider network.
Reimbursement is an evolving issue.
We are having discussions with our local health departments who are interested in exploring other opportunities for administrative claiming.
That could be another whole topic area.
Emerging phases for us are to collaborate with more complex needs.
Moving on to the gaps in care.
Where we have made some strides but we still need to do a lot of work is in oral health.
We've tried to help mobilize the provider shortage.
There are more clinics in our state where we do have the shortage areas.
I believe Title V is supporting some of these local health department clinics.
Another area where we work to fix a problem is and to fill a gap was the breast cancer arena.

We've been with Medicaid for women who sl been screened through public programs but had no access for treatment services.
I think that has been an important collaborative for us as well and the successes we wanted to highlight.

In addressing complex needs, we really need Title V's expertise to collaborate -- I think this is another area where I don't know about other states but we're really drowning in case management programs yet they aren't coordinated.
Very complex needs are in multiple systems.
We're requiring case management and care coordination of the managed care organizations.
They're doing case management.
Hygiene is doing case management and these children are in various systems and we need to work together to find a better way to assure that children get the services they need.
Indeed, some of our core values contribute to some of those problems but it's something that we have to overcome.
For instance, having the mental health carve-out could create some of those issues but yet it has in many ways been services to the population.
Multiple state and local agencies involved and we find that sometimes as agencies we would like to collaborate but they're reluctant to come to the table because you're expected to bring your resources and none of us have resources right now.

In conclusion the partnership is essential.
We must be flexible.
Managed care does support this.
Many of our initiatives really value our Title V partners.
We're more effective working together.
We do not have this marriage on paper.
It is a reality and our day-to-day.
We're committed to it and look forward to it.
Thank you very much for having me present.

JAMES RESNICK: Thank you very, very much.
Now my pleasure to introduce Peggy Bailey who works with the association for maternal and child health programs commonly known as AMCHP.
She's a health policy analyst and the title of her presentation will be, making the case, why state Medicaid and Title V agencies should forge partnership.
Thank you very much, Peggy, for being with us.

PEGGY BAILEY: Thank you.
And I appreciate the opportunity to make this presentation to you.
Actually, my presentation is going to pull out a lot of the points that Rosemary covered in her presentation, which is good.
It will -- it is going to pull out a lot of the reasons why Maryland made the choice to work -- to make a partnership between Medicaid and Title V.

Basically what brings us both to the table is that we're serving kids.
For 70 years and 40 years Title V and Medicaid have been working to try to serve children and the uniqueness of each of the programs mean they partner together well and they fit well together through a lot of hard work from the Title V and Medicaid agency.
Both programs are essential to being able to provide quality and consistent services to kids.
And so therefore just as Rosemary said, a partnership between Title V and Medicaid isn't just a nice idea, it's essential.
Although there are a few federal statute requirements that help this partnership.
Title V is required to partner with state agencies to help coordinate their systems.

So that's part of what Title V brings to the table.
Title V is charged with helping Medicaid identify eligibles for Medicaid.
Part of Title V's role is to do out reach and enrollment for Medicaid so it freest up Medicare dollars to require the services.
They require the normal agreements.
Having a memo of understanding and being very detailed about what it is that Title V and Medicaid expect to get out of their partnership.
And Title V is the payer of last resort.
Medicaid and S-chip are required to pay for services.
One of the problems that states have faced in trying to forge this partnership is overcoming some very fundamental language barriers.
In the recent Medicaid reform debate, the success of Medicaid was often talked about in terms of cost and controlling costs and their ability to control costs and there was little discussion about the benefits or quality of services that people have been able to report they've been getting from Medicaid.
As far as MCH is concerned their success is often determined by the number of people reached and the populations reached and the quality of those services the populations get.

Although it doesn't sound like that should be a problem.
If you're coming at partnering from those different angles it can cause differences in how to approach the situation at hand.
So it's important to acknowledge those differences and how the programs are judged by the public and then work to bring those -- the programs together to solve -- to achieve both of the goals.
Now, the reason you partner with anyone is because everyone has challenges and things that they're good at to be able to make a program whole.

So Medicaid's challenges are that the program has grown beyond its original intent.
It was created in 1965 and has expanded over the years to do much more than what the original intent of the program was, which causes problems.
The program also has very stringent requirements that Congress has laid down and that the program has to follow which can hurt the flexibility of the program.
Also, 2/3 of the cost of Medicaid go to about 1/3 of the participants.
Sometimes it's hard to control those costs because that 1/3 of participants are seniors and it can be politically difficult to cut services to seniors.
Not that we want to.
It can be politically difficult.
Sometimes the programs for kids and women are the ones that get addressed in budget cuts.
What does MCH bring to the table?

The Title V block grant is a very flexible funding source that allows Medicaid it might not have within its own problem, the flexibility.
Title V's role is outreach and enrollment.
Medicaid can use its funds for other things if Title V can find the kids.
There are a strong history of performance measures within Title V and strong expertise in developing services.
Title V funds can be used for wrap around services as Rosemary indicated.
Title V and Medicaid can be partnered to make a whole program for a child as well as incremental healthcare services.
In the same vain Title V has challenges.
The MCH block grant is a relatively small funding stream so that they often have the make miracles happen with small amounts of money.
What -- and this can be difficult.
There is a broad vision of Title V.

The mission of Title V is broad and sometimes difficult to explain outside the health community when it's confusing when you try to explain to policy maker what Title V does.
Along with that sometimes it lacks the public recognition it reserves because the services are invisible to the general public.
Which is good, people shouldn't necessarily know when they go into a clinic that clinic is funded with Title V dollars but it can hurt when you're trying to make a case for why MCH funds need to be increased or maintained at the state level.

How does Medicaid help us overcome those issues?
There is money in Medicaid and Medicaid provides direct reimbursement to providers.
As we all know doctors like to get paid for what they're doing.
Medicaid brings that money to the table.
EPSDT is mandatory so it is something that Medicaid has to provide.
And so it is important to bring Title V in since Title V also as opposed to Medicaid with providing that services.
The growing number of studies show that families and participants are happy with their Medicaid coverage especially families of children with special healthcare needs.

There have been studies that show these families get better care than families that have private insurance.
So that can help with state and policy makers and the general public to help raise the profile of Title V and Medicaid and the strong political leverage that Medicaid has within the state because there are so many funds that go into Medicaid it gets a lot of attention.
If Title V can show how they can help Medicaid control costs everybody wins at the state level.
We need to partner because we serve kids and we have to do the best we can to get children the healthcare services they need.
We have challenges to overcome but we also both have things we bring to the table that help us serve those kids.
Even though none of this is easy, because we have the goal of serving kids, collaboration must happen.

JAMES RESNICK: Thank you very much, Peggy.
We're now going to move to Washington State in Seattle where we'll be having a presentation entitled, coming to the table, Medicaid, Title V and the local health department working together to improve the health of children.
The Washington State experience.
We'll now be moving to bash, -- Washington State where I'll let the speakers introduce themselves.

MARGARET WILSON: Thank you for letting us speak to you today.
I'm Margaret Wilson and I work for medical assistance administration which is the Medicaid agency in Washington State.
The Title V agency in Washington State is the Department of Health.
We both have a long history of partnering with other groups in our state to accomplish the goal of getting EPSDT services to Medicaid children.

Our goal of collaboration is working with our partners to improve both the access and the quality of EPSDT services to children and adolescents.
We approach the EPSDT program as two-fold.
Getting the kids into the care.
The things we were talking about earlier.
Also when they are to the doctor that it's quality of care.
The needed services are performed and treatment and referals are made when appropriate.
We have approached that in a two-fold way.
Some of the strategies we came up with to accomplish that are we have developed a community approach to child health and development services.
We unify -- we work to unify and improve our health and development information and education to parents and families so that they know what it is expected to happen at the EPSDT, what are their choices, what is going to happen, those sort of things.

And we collaborate with our partners in identifying and implementing strategies for improving the services of the EPSDT.
We work with the Department of Health who I've been talking about.
We also partner with the University of Washington, with local health jurisdictions from throughout the state.
Children's administration which is responsible for foster kids.
Managed care plans.
We're a very strong managed care state.
Our managed care plans work with us to try to get those services for our children.
Our Washington chapter of the AAP is a very active participant and also the participation of our local school districts and school nurses to help us get kids into care.
I just wanted to give you a couple of examples of some activities that we work together on that have been very successful of accomplishing our goals of the EPSDT and the quality of the exam.

The first thing I wanted to talk about was we, in the last few years, we've developed a set of well child exam charting forms for the providers to use when they're charting the results of their EPSDT exam.
What is unique about them is we kind of decided what it was we wanted to accomplish with this charting forms and they're NCR, two forms.
The front of -- I realize you can't see these but at the bottom of the next slide will be the website so you can go and see them.
But the top part, the front part is where the physician checks off the different components of the EPSDT exam.

And the back of the first sheet is instructions to the physician, for example, about fluoride, immunizations, that sort of thing.
The next copy is an NCR form where the parent will get a copy of the exam and what we have determined there is they could use that for a head start exam, school physical or camp physical, that sort of thing.
They have a record for their own record keeping of what that exam entailed.
Who did it, what was the result.
On the back of the form there is health messages and growth and development information and referral information back they can use for that specific age group.
We have 18 of these forms.
They're all different ages.
Two weeks, two weeks, four months, six months, nine months, you get the idea.
More earlier in live, obviously.
And they go to 18.
They're also available on our website in seven different languages in addition to English.
They can use them or they can modify their own record keeping depending on what their organization wants to do.
But we made sure we had all the components of the EPSDT exam on the forms so that we have a record of it when we do chart reviews.
The second example that I wanted to talk about is the form used several years ago on the improvement teams that includes those partners I mentioned earlier and the goal of the team was to work collaboratively on the EPSDT problems and issues that come up and work at a problem-solving way.
Sometimes we've had task forces from that committee.
That's where the forms came out of is that improvement team.
We meet quarterly and we have a broad representation of stakeholders.
We just work on issues that are current to our state at whatever comes up from either managed care, Department of Health or whatever.
And I'm going to turn the camera over to Lorrie to introduce herself.

LORRIE GREVSTAD: Thank you for the opportunity to be part of this conference and to share with you some of the work that is going on in Washington State and for the opportunity I don't get very often to say good morning to some and good afternoon to others.
I'm Lorrie Grevstad and I work for maternal and child health in the Washington State Department of Health.
I want to share with you the keys we found with our local health jurisdictions.

I want to focus and be able to identify.
You have heard a lot today about partnerships but to be clear that they are as important as the state levels and across those agencies as it is at the local level in working with our local health jurisdictions and other coalitions and work groups that are in communities that are dealing with children's issues and those of teens and adolescents.
In our area, it's easy to focus on some of the work we're doing now because of some examples I'll be sharing with you on a younger population.
But want to be sure that we address and talk about the partnerships are equally important to reach across the age spectrum as it relates to EPSDT issues and needs.

It's important to build on existing programs and opportunities.
We've been able to do this within Title V in a number of the traditional areas you've heard from previous presenters.
But also to try and identify where you may have unique opportunities to reach out or look for connections with partners as mentioned potentially in oral health with dentists hygienists and other providers concerned with oral health issues.
It is difficult both for access and being able to connect children to those services.
Also in the area of social and emotional behavioral issues, children's mental health and the ability to expand and do more EPSDT screenings that are inclusive of those services.
And our school partners, one of the opportunities we've had in Washington is with a program called steps which is looking at all the transition issues that children have starting from birth when they go home from the hospital, going all the way through leaving home, with parents, childcare, early childhood, pre-school, kindergarten.

There are a number of children across the country who are no longer cared for at home, since parents are having to work, there are more issues to connect to out of home care programs before and after school programs, and other areas where traditionally material has been developed by Title V and MCH for parents.
Now thinking about other audiences where that information can be useful.
I'll quickly go over the partnerships.
Many of them have been mentioned.
Washington chapter of the American academy of pediatrics.
Local health jurisdictions.
Schools, both before and after school programs.
Programs that might be based out of faith-based communities.
YMCA, etcetera.

Thinking about connections with head start and early childhood programs, pre-school programs, and working with your state resource and referral agencies or network should you have that in your state.
Working where teens meet at teen health centers, teen centers and programs.
Working with managed care.
Working with your healthy mothers, healthy babies program if you have that in your state and in our state a program called first steps.
That is there for pre-natal care to women and for the infant and newborn after that.

I commented on the importance of building on existing programs. That's been one of the areas where we've been able to have a great deal of success.
One of those unique areas is a program called healthy childcare Washington which is part of the national Maternal and Child Health Bureau called healthy child America.
That has provided us with system level capability to connect health and safety in childcare and early childhood.
Through that program we've trained over 80 public health professionals.
The majority of them public health nurses, to become childcare health consultants.
They are available in each of the 35 local health jurisdictions of Washington State.

Many of those public health staff and nurses were previously trained in EPSDT exams and well child and in a program called incast which was a nurse/child assessment program known in many areas across the country.
That program has allowed us, because of components inherent in it, to make connections with MAA and EPSDT to again reach out to a non-traditional audience.
Childcare and early childhood providers who are equally concerned about the health of the children that they serve during the day.
And recognize that the information that traditionally had gone to parents now needs to go with those providers and they encourage as they check for immunizations and other health issues about the children that they're caring for that EPSDT and well child exams is one of the areas they ask about and include in their discussions with parents.
Another area is reaching out specifically in programs through our maternal child health options in Title V in the area of where we have traditionally, as I mentioned, the programs were designed for parents and medical providers.

Now we're using to reach the other audience like I mentioned early childcare, before and after school programs.
Those are the bright futures, using bright futures materials.
We've adopted them so they can be used with other audiences.
As I've mentioned, childcare, early childhood and with some of our school age programs.

In Washington State we have a program called child profile.
It's the immunization registry system to ensure that Washington's children receive prevention care that they need.
Those materials are also being -- some have been adapted and some are in progress to each out to these other audiences.
Some of you won't be able to see this but I have a small plastic folder which is about the size of my hand that has been created through child profile, MAA and healthy mothers/healthy babies as a partnership.
It has the lifetime immunization record.
Dental care, safety tips.
Health screenings and well child exam and creates a permanent record for parents and this is provided.
We help provide that also and make available where we can through childcare providers where they're interested.
Also to be sure and reach out where you can through your Title V programs with adolescent health.
Whether they're teen centers or to think creatively.
Whatever the programs may be in your state, maybe through teen pregnancy programs, possibly through education grants, etcetera.

Although their focus may be in other areas they're a captive audience to try to recognize the importance of well child or adolescent and middle school children.
We've also partnered more commonly with the wick programs with our children with special healthcare needs with the earlyber vention program in the state and with our maternal infant program.
I've talked about reaching children and adolescents where they are.
Recognizing that children are not always where we've traditionally reached them and with large, hundreds of thousands of children a day in out of home care and before and after school.
You think about the opportunities that creates for sharing and encouraging well child and EPSDT activities.
Lesson learned.
It takes time but it's worth it.
Partnerships always take an additional opportunity and an activity to reach out.
But for us it's proven to be well worth it.

It has helped us as both Peggy and Rosemary shared earlier to leverage and expand the opportunities that neither program might have on its own.
It has allowed us to expand other grant opportunities that might not have been there through our partnerships and those grants have allowed us to creatively look at ways and test new ground for programs that we might not have done in traditional circumstances.

I would just like to reemphasize to the Title V program the population, not just in the ability of Title V programs to provide direct services which many no longer do but to recognize that out of population base -- in population-based approaches we can expand and address a lot of children and lastly to recognize and continue whatever efforts each state can do to evaluate those programs as they're doing them.
Modify them as they go along for quality.
I'll turn the program over to Lisa for a more local perspective.

LISA PODELL: Through very much.
I'm Lisa Podell, the program manager for the kids get care program with the public health in Seattle and king county.
It's the largest program under the action plan.
We're doing very similar things to what Lori has spoken about.
But on a county level.
King county is a large urban county, as you can imagine, where Seattle is located.

The goal of kids get care is to ensure that children, regardless of insurance status, receive early, integrated physical, oral, developmental and mental health services through attachment to a healthcare home.
I'm going to stop just a minute and define that for you.
Most of you are familiar with the term medical home.
Because we're an integrated health program, because we integrate physical, oral
developmental and mental health we use the term healthcare home.
But for all intents and purposes it's the same as a medical home.
So the impetus for the program was that despite major efforts to enroll kids in health insurance, there really wasn't any evidence that kids were getting the care they needed or getting healthier.
In fact, as you can see on this slide and since I'm moving quickly through some of these, I'm on slide number 4, there was just a whole host of needs, a whole host of problems.

You can see that these are 2001 numbers here, but only 2% of the kids in wash -- 21% had a complete well child check meeting all four health domains.

Kids who didn't have a healthcare home or had low continuity had much higher emergency room visits, more hospitalizations.
There were more behavioral and emotional problems and, of course, much less dental care utilization.
So when this program was started, we worked with the existing infrastructure and here is your collaboration again. On a more local level. So we worked with community health centers. These are mostly centers with hospitals and of course with the Department of Health and with MAA sitting here.
But most importantly with community-based agencies as Lori says, where children spend time.

That's head start, pre-schools, the WIC program.
The main things we try to do are to turn that equation around.
Use access.
Access to care or to use care as access to insurance.
And to emphasize integrative, preventive services.
Early identification care. To get to the EPSDT we used what we use what we call a web and funnel approach.
Start in the community where the kids are and we use a train the trainer methodology.
We go into community-based organizations.
These are head start and WIC and homeless shelters, places like that.
And we work with a staff there.
We train them to recognize developmental problems.

Mental health also.
And also oral health problems.
Have a tool that we've developed.
It's called the red flags developmental surveillance tool.
And there is -- it's a few slides up we'll get to it.
It's on our website.
There is a reference to it.
But we train the staff to be able to scan kids using that tool.
And to use that as basically ammunition with families to -- to use it as a tool to families they work with.
Make sure that they bring their kids in for the EPSDT.
And to emphasize preventive care because in king county especially, we have a lot of immigrants.
And many immigrants, many of the populations come from cultures where preventive care is not there.
To bring your perfectly healthy child in for a preventive exam is literally not part of the culture.

So this train the trainer approach, as you can see here, gives us a big effect.

It really casts a wide web in the 18 months -- in the first 18 months of the project we are able to train 2300 health professionals and staff and that results in about 25,000 kids being serviced in an effective way to use the limited resources.
Once we get them in that web, then we have them refer kids to our hub sites.
These are mostly community health centers and there we have case management.
And that is what we consider our glue.
They glue the kids in to healthcare homes and there we really concentrate on seize the moment kind of approach.
And to give you a few examples of that, that's the idea that when the child is seeing a dentist, that dentist has a much wider way of thinking and will ask the child when the last time they had a well child exam.

If they haven't had one, whoops, send them over for the EPSDT.
And we train the physicians and primary care providers, instead of looking over the teeth to the tonsils, do a complete oral health screening.
Reconnecting the mind, mouth and body and doing that care.
I'm actually going to skip over this next slide.
It's a bit complex.
I've left it in there so if you want to go ahead and look at it.
It's the way we put the whole model together, the community piece, the clinic piece, our ABCD, early screening kids.
Not only screening kids but providing more dental access for young kids, putting the whole program together.
But for the sake of interest of time I'm not going to go into it right now.
But as you can see on the next slide, I'm on number nine now.

All of this together has led to a great deal of success for us.
These are 18-month achievement numbers here.
We've been able to establish medical homes for over 5,000 children.
We've increased the number of well child checks.
Our sites have been able to provide by up to 55%, an average of 55%, all without an increase in provider or physician with these tools we're talking about, case managers, and community screening.
Specifically we look at 2-year-olds.
They're up to date by an increase of 38% and the reason we're shining a light on those 2-year-olds is because we're study over 300,000 kids.
It shows that when 2-year-olds are up to date they're 48% less likely to have avoid able hospitalization.
Which is a pretty powerful number.

We have a lot of folks in Washington interested in those numbers.
The fact that that can have.

I won't read through the rest of these here but on here and the oral health part of our program similarly powerful results, one clinic out of -- had a 66% increase in the number of oral health screenings they've been able to do.
Another nearly 50% increase at the toddlers at the clinic which, of course, just makes them much more able to prevent that spread early in a child's life.
So a minute ago I mentioned those tools are surveillance.
They're on our website which is listed here.
In fact, what we've tried to do, because we are in one county, is to really boil a lot of this down to pools.
We have what we call a recipe.
You put in a cup of this, and you get -- kids get care.
You get the kind of success that we've had.

So we have our little recipe because we feel that this is a very good program.
We have it down to our recipe which is available through our website.
I don't have time to go into too much detail here but we really look at this not so much as a program now but as a system change because that's the only way to make much progress as to change a whole system.

Not only is it able to be replicated but it really is a way of changing an entire system in that in our community sites and in our clinics, when our grant funds run out or change, the processes stay in the clinics, in the community sites.
Our sites have changed the way they provide care.
The way they screen children so that these ideas and these processes will live on and they can have -- they have cost savings now that they'll reinvest.
They're now working with our state.

JAMES RESNICK: We have received questions from participants through the web and I would like to now send -- ask a few questions of the speakers, if you don't mind.
And those who are submitting questions again it's very important that you tell us who the question is for.
And that way we can move forward.
So this question is for Lisa.
Can you tell us -- can you tell us the website for the kids care program?
Can you repeat the website address again, please?

LISA PODELL: I'll also direct you for those of you looking at slides it's on slide number 11 and it's WWW.metro KC as in king county, .Gov/health/KGS.

JAMES RESNICK: Thank you very much.
I just wanted to let people know that this webcast will be archived and will be available probably in about a week on WWW.MCH com.com.
OK.
The next question is again for Washington State.
Is the EPSDT form utilized by Washington State -- will the state be required to adopt the 1500 to meet HIPA guidelines?

MARGARET WILSON: Let me make sure I get the question right.
Are my EPSDT charting forms HIPA compliant?
As far as I'm aware, it is.
Because a -- if the person is addressing the confidentiality part.
The parent is filling out the top part and answerering some questions and if they take the -- the carbon copy like to a head start exam the parents carrying it so it's implicit consent or implied consent, I think.
And what about the 1500?
What was that?

JAMES RESNICK: The next part of the question -- I have to apologize.

MARGARET WILSON: That's OK.
Anyway.

JAMES RESNICK: Will the state be required to adopt the 1500 to meet HIPA guidelines?

MARGARET WILSON: I believe we've already done that because isn't the deadline October 1 or something?
I don't know enough about the 1500 to answer that question, to be honest.

JAMES RESNICK: I'm going to the next -- can you also repeat the website for the EPSDT forms?
The Washington State?

MARGARET WILSON: Yes, just a minute.
I have to look it up.
Make sure I get it right.

It's on slide number 7, WWW.WA.GOV/DHSH/DHSH forms and then/forms/E forms ---if you enter the website you can get to the form.
We do have it on our website so you can look at it and it does come in different languages.
But we encourage the physicians and nurse practitioners to order the forms from us.
If you download them off the web they aren't NCR.
I want to be clear about that.
I don't think I said that earlier.

JAMES RESNICK: I was going to say the website address has also been put on the computer for viewers to see.

MARGARET WILSON: Thank you.
It is complicated.

JAMER RESNICK: This question is for any of the speakers.
Do any of the Title V programs you work with provide grants to federally qualified health centers?
Does anyone care to answer that?

PEGGY BAILEY: I would imagine so.
But -- this is Peggy Bailey.
I would imagine that some do.

JAMES RESNICK: This question is for Cindy Ruff.
They're not documenting the EPSDT services and not documenting them properly in the child's record.
Do you have any suggestions for doctors to record them?

CINDY RUFF: I think one of the things states can do is develop forms.
They have very specific forms they send to the providers and the providers are required to use those forms in order for them to be documented as EPSDT and in some cases the state will actually pay extra money if that form is submitted.
That's about the best way that I can think of that I've heard of states using.

JAMES RESNICK: Question.
This is for Cindy Ruff as well.
If every encounter with a healthcare professional is considered a screen, how is the data captured?
Does it only happen with a specific code?

CINDY RUFF: The only screenings we're concerned about getting data on are the initial or periodic screenings.
They're the ones that are on the state's schedule and the ones that collected with 416.
The definition of a screen, the broad definition of a screen was only -- only came about because we wanted to make sure that children would had preexisting conditions.
Children born with certain conditions were not left out of the broad realm of treatment programs.
The statute does say that a condition has to be discovered by a screen.
So the definition of a screen for purposes of providing treatment does not really relate to the data that we need because we're only counting those initial and periodic screens.

JAMES RESNICK: Great.
Another question for Cindy Ruff.
A question about dual eligibles relative to the 416s.
As states increase eligibility income levels more children have dual coverage.
When a child goes for a well-child visit the primary carrier covers the cost.
The balance of out-of-pocket charges are submitted to the Medicaid agency to cover the cost of any deductible or co-payments.
The problem is that Medicaid agency counts the payment not to the provider as simply co-payment, not a well child visit.
That service is provided but not recorded on the 416.
In our state upwards of 25% of children have dual coverage.
Can you consider a system that could toss out those children from the denominator because they're tossed out from the enumerateor already?

CINDY RUFF: I'm looking at our 416 instructions which do indicate that individuals for whom there is third party liability should be counted as eligible for EPSDT.
I think the thinking behind that was that many of these children, while they have insurance, that insurance does not cover the preventive part of the services.
I don't know that we've considered tossing those numbers out.
It is a suggestion that we would certainly look at in any revision to a data form that we may do.
But I'm not aware that we're going to be doing that any time soon.

JAMES RESNICK: Peggy, this is a question for you.
Are you aware of any Title V programs that actually do the EPSDT screen for children seen in the Title V clinics?

PEGGY BAILEY: Specific examples of them?

JAMES RESNICK: Yes.

PEGGY BAILEY: I don't -- it would be hard to imagine states that don't.
But I would have to get back to them on exactly which states do and which states don't.

JAMES RESNICK: This question is for Washington State.
How does Washington State bill Medicaid for EPSDT services?

MARGARET WILSON: How does Washington State bill Medicaid?

JAMES RESNICK: For EPSDT services.

MARGARET WILSON: Well, most of our kids are in managed care plans so we pay a per month per member fee.
And we require them to provide the schedule that we've set.
I'm not sure I'm really following the question.
Some kids are fee for service and they just bill us for an exam.

JAMES RESNICK: Lisa, we've just presented an oral risk assessment to physicians in our areas.
They were less than receptive because of time restraints and more paperwork.
Do you have any suggestions?

LISA PODELL: Yeah.
Well, there is a couple things.
What we've found, actually, is that the -- doing the fluoride varnishs themselves the physicians seem resistance that they've seem to have compromised.
They are happy to do the additional risk assessment but the fluoride varnishs they like to hand off to dental clinics assuming they're co-located.
We're happy enough with that.
As long as it gets done.
Where they're not co-located, we're doing some work on making sure that it happens.
But they seem to feel that the screening and everything else doesn't take all that much time to do additional screening, it's the fluoride varnish itself that bogs them down.
Does that answer the question?

MARGARET WILSON: If I could add in there that the Medicaid does pay an additional fee for fluoride varnish, $13.39.

Even if they are managed care plans we'll pay that outside of the managed care fee.
We're trying to instigate a little more of that varnish application.

JAMES RESNICK: Great.
This is also for Lisa Podell.
I think it's great to train pediatricians to do oral health screenings.
Are you able to link the children for dental health?
Has it helped more dentists participate in Medicaid?

LISA PODELL: Absolutely.
They're very much linked.
We don't just do the screening.
It is screening and linkage.
It is kind of a three-part process.
Screening and risk assessment and linkage.
That's where the case manager comes in also.
So a part of it is is figuring out so they screen them, they do a risk assessment, make sure they have a dental home and get them to a dentist.
Part of it, which I was trying to save time there is we also have -- we have two things going on.
We have dental clinics that we can refer to.
Many of our sites have dental clinics themselves and then we have another program in Washington State called ABCD which is called access to baby and child dentistry which is where the local dental society recruits private dentists to see children from birth to up to age 6 for particularly preventive but also restorative care.
We're piggybacking these programs together.

JAMES RESNICK: Great.
Before we get to one of our last questions, I would encourage anybody else who has a question to please submit it now.
Before we conclude this presentation.
This is for Washington State.
They have a question concerning how you are partnering with Indian health organizations.
That's the question.

MARGARET WILSON: I can just -- we were just consulting who was going to answer that.
In Washington State our tribal councils are included in our EPSDT improvement.
Some of them are under the managed care plans and some aren't.
So it depends on their focus.

If they have Indian clinics we go there and help train them about EPSDT services and have the charting forms available to them.
Include them in our activities.
And some of our areas the children come to clinics such as Lisa was talking about.
So they would be included.

LORRIE GREVSTAD: We also have some childcare health consultants, as I mentioned earlier, this is Lorrie, trained in some of the tribal and reservation areas and so they are also working there to try and make better connections for EPSDT and also including them in our conversations with our new comprehensive early childhood systems grant through the Maternal and Child Health Bureau to recognize them as a stakeholder to do some additional planning and work to identify linkages for accessing children to health insurance, medical home and including EPSDT activities.

JAMES RESNICK: This message is for -- this question is for Cindy. Is comprehensive asthma management covered under EPSDT, this would include clinical and environmental control of asthma.

CINDY RUFF: As part of a child's normal EPSDT screening the health education certainly if a child has asthma, any kind of medical and treatment services would be covered.
The specific name that Jamie just read is not a comparable Medicaid service in the list of services.
However, I think it would be included as part of a physician service.
If something was needed beyond that the state would need to determine the medical necessity of that service.
I would mention we don't generally cover environmental services.
It would strictly need to be a medical portion of any service provided to that child.

JAMES RESNICK: Also for you, is the CMS416 going to change to allow capture of services that occurred but were not build because of the pre-care rules by local health departments?

CINDY RUFF: Well, I don't know of any plan to change the 416 at this moment.
We understand that there is a problem capturing data when Medicaid doesn't pay for the service it's very difficult to get that information.
If the state can find a way to collect that information, they certainly can report it on the 416.
But I'm not aware of any change to address that problem specifically.

JAMES RESNICK: Then the last question is for you.
How does--

CINDY RUFF: I'm afraid I don't know the answer to that question.
I mean the 416 doesn't change just because of HIPA.
In fact, we're hoping that HIPA will improve the data that states collect and will in turn improve the data that is mon -- mandatory for states to collect.
I'm not familiar with HIPA enough to know exactly how that will work.

JAMES RESNICK: Are there any other questions in rockville or on the web?
Great.
Well, I want to thank everybody for tuning in to this EPSDT webcast.
Again I would like to thank all of the presenters who really do an outstanding job and really provide important information on this topic.
I would just like to remind everybody again that this webcast will be archived and available in about a week and it can be found at WWW.MCHCOM.COM.
Thank you and have a good day.